



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line (888) 700-5330

To Report Adult Abuse: (800) 564-1612

March 6, 2020

Mr. Ron Cioffi, Director  
Vna & Hospice Of The Southwest Region Inc  
7 Albert Cree  
Rutland, VT 05701-4648

Provider Number: 477007

Dear Mr. Cioffi:

On **March 4, 2020** staff from the Division of Licensing and Protection conducted a complaint investigation at Vna & Hospice Of The Southwest Region, Inc. The purpose of the survey was to determine if your agency was in compliance with Federal participation requirements for a Home Health Agency participating in the Medicare/Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements.

Sincerely,

A handwritten signature in cursive script, appearing to read "Suzanne Leavitt".

Suzanne Leavitt, RN, MS  
State Survey Agency Director  
Assistant Division Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>477007</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/04/2020</b>	
NAME OF PROVIDER OR SUPPLIER  <b>VNA &amp; HOSPICE OF THE SOUTHWEST REGION INC</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>7 ALBERT CREE</b> <b>RUTLAND, VT 05701</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	INITIAL COMMENTS  An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 3/4/2020 and the agency was found to be in substantial compliance.			G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.